# APPLICATION FOR RELICENSURE TO OPERATE A CRITICAL ACCESS HOSPITAL (CAH)

FOR OFFICE USE ONLY

Date _____

Amount _____

## I. IDENTIFICATION

Name of Facility _____

Address _____

City/County/Zip _____

Telephone Number _____

Administrator _____

Date facility began operation at current address _____

Date facility began operation under current owner _____

## II. CONTROL (Circle one in each column)

| | | |
|---|---|---|
| State | Profit | Individual |
| County | Nonprofit | Partnership |
| City | | Corporation |
| Private | | |

Name and address of direct owner

_____

_____

_____

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

(OVER)

## III. TYPE BEDS

| | Current | Requested |
|---|---|---|
| CAH | | |
| Swing | | |

KRS 216.380 (3)(a) requires that at least one of the following criteria is met in order for a licensed acute care hospital to be relicensed as a critical access hospital. **Check the appropriate criteria listed below and submit the supporting documentation.**

The hospital is:

_____ Located more than a thirty-five (35) mile drive from another hospital or other health facility.

_____ Where the terrain is mountainous or only secondary roads are available, the hospital is located more than a fifteen (15) mile drive from another hospital or other health facility.

_____ The hospital is certified by the Secretary of the Cabinet for Health Services as a necessary provider of health care services to area residents.

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time.

I agree that this service and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel.

I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

_____ _____ _____

Signature of Authorized Representative | Title | Date

Return application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 242A

(10/2002)